STATE OF MICHIGAN

DEPARTMENT OF LICENSING & REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

v **File No. 121286-001**

Madison National Life Insurance Company

Respondent

_____/

Issued and entered
this 19th day of December 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On July 5, 2011, XXXXX, authorized representative of XXXXX (Petitioner), filed a request with the Commissioner of Financial and Insurance Regulation for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. After a preliminary review of the information received, the Commissioner accepted the request on July 12, 2011.

The Petitioner receives health care benefits from a group plan that is sponsored by the XXXXX Association of Michigan and underwritten by Madison National Life Insurance Company (Madison). The Commissioner immediately notified Madison of the request for external review and asked for the information it used to make its final adverse determination. CAM Administrative Services (CAMADS), a third party administrator, administers the group health plan and responded for Madison.

This case involves medical issues so the Commissioner assigned the matter to an independent review organization which completed its review and sent its recommendation to the Commissioner on August 2, 2011.

II. FACTUAL BACKGROUND

The Petitioner receives health care benefits as an eligible dependent. Those benefits are defined in the *CAM Benefit Program Certificate of Group Medical Insurance* (the certificate) issued by CAMADS.

On Saturday, April 24, 2010, the Petitioner went to a hospital emergency room (ER). The attending ER physician ordered chest x-rays and completed an examination. The Petitioner was diagnosed with acute sinusitis, pharyngitis, vertigo, cough, and headache and was discharged from the ER with a prescription for an antibiotic.

When the claims for the ER care were submitted, CAMADS denied them on the basis that the Petitioner's condition did not warrant emergency treatment as defined in the certificate. An internal appeal of the denial was submitted to CAMADS on the Petitioner's behalf by the hospital where the ER visit took place. CAMADS reviewed the matter and then notified the hospital of its decision to affirm its denial in a letter dated October 25, 2010.[1] For the purposes of this review, the denial letter of October 25, 2010, will be treated as CAMADS'S final adverse determination. The Petitioner now seeks a review of that determination by the Commissioner.

III. ISSUE

Did CAMADS correctly deny coverage for the Petitioner's ER care?

IV. ANALYSIS - A

In its final adverse determination of October 25, 2010, CAMADS advised:

> Grievance Committee review of the documentation provided was not able to determine that the April 24, 2010 services meet the . . . stated policy definition of an emergency. As a result, the original denial of the expenses was appropriate, and does remain the patient's responsibility. There will be no adjustment of charges.

It is CAMADS's position that the Petitioner did not require emergency medical care when he went to the ER and therefore the treatment was not a covered medical expense under the terms of the certificate. CAMADS cited several provisions in the certificate to support its decision. The benefit for emergency medical care is described on p. 10:

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1 The Petitioner's request for an external review on July 5, 2011, is deemed to be timely because there is nothing in the record to show that CAMADS had informed the Petitioner, or the hospital that represented him in the internal grievance process, of the right to seek a review of the denial as required by Section 7 of the Patient's Right to Independent Review Act, MCL 550.1907.

> **4.07** **Emergency Medical Care**. Covered Medical Expenses for Out-Patient Emergency Treatment include charges resulting from an Injury or a Sickness which, unless immediately treated, could reasonably be expected to result in the loss of the patient's life or a serious health impairment.

"Emergency" is defined (p. 42):

> **EMERGENCY** - means an Injury or a Sickness which, unless immediately treated, could reasonably be expected to result in the loss of the patient's life or a serious health impairment.

The certificate also contains the following exclusions (p. 18, 20):

> **GENERAL EXCLUSIONS**
>
> The following charges are not Covered Medical Expenses:
>
> * * *
>
> (55) Charges for services provided as an Out-Patient which could have been provided in the doctor's office.
>
> (56) Hospital emergency room charges that were not related to an Emergency.

CAMADS gave its reasons for its belief that the Petitioner did not need treatment on an emergency basis:

> Review of the emergency records provided found that the [Petitioner] had a 4 week history of sickness symptoms without any evidence that he sought treatment from a physician during that period. Records further state that the [Petitioner] participated in a school sponsored athletic event during the morning of April 24, 2010 and did not present to the emergency room until 9:37 that evening.
>
> According to billed charges, services provided were such that all could have been performed at an urgent care center or physician's office. If services were rendered that required the medical equipment and staffing a hospital provides this may have supported this particular case to reverse the denial. As out-patient emergency expenses not related to an emergency are policy exclusions the denial of services has been maintained.[2]

2 May 25, 2011, letter to the Office of Financial and Insurance Regulation in response to a complaint filed by the Petitioner.

The Petitioner, a college student, explained his reason for seeking emergency treatment:

> On April 24, 2010, I . . . participated in a rowing regatta. . . . Prior to the regatta, I felt light headed and weak, which was extremely rare. Focused on the race to come I pushed these symptoms aside and continued to stretch before our water warm-up before the race. During the stretches my light-headedness and weakness started to go away which at the time I thought was because I was a little dehydrated from another long week of practice and lifting for the team. Once the stretches were over our crew proceeded to warm-up on the water in our 8-man boat. Throughout the warm-up on the water my symptoms progressively got worse now with an extreme headache. Once we arrived at the starting line for the race, I asked my teammate in front of me how I was looking during the warm-ups. Once he turned around he noticed that blood started pouring out of my nose and each time my headache pulsed it felt as if more blood kept pouring out. Before I knew it the race was underway and I was forced to row the whole race with my nosebleed and headache. After the race was finished . . . my coach and teammate carried me out of the boat to the boathouse in where they brought me drinks and food as we waited for the nose bleed and headache to diminish. After this, my parents were informed of my condition and my coach insisted I [go] to the hospital to make sure everything was all right. I for one was scared of my condition since this has never happed before to me between sports and lifting. I wasn't sure if I was sick, over exhausted or it was a sign of something else that I was unaware of since brain aneurisms run in my mother's family line. Going to the hospital and getting chest x-rays done were the only convincing and necessary way to make sure that everything was going to be okay. Once I arrived at the emergency room, my headache was still throbbing and my nosebleed had stopped. I then was brought back into one of the patient rooms where the doctor did his initial exam and assessed the information given to him by my father and I. He declared that it was just a bad head cold and gave me medicine there to help with the pain and gave me a prescription for home/school use. He also administered a chest x-ray to just make sure everything was all right. Once the results came back negative I was sent on my way with my father.

The Petitioner's father (his authorized representative) offered his reasons why the Petitioner was taken to the ER:

> . . . My son was very sick. We do not use the emergency room for minor illness. We were concerned for his well being. He could barely stand up, was having trouble breathing and had two bloody noses. The doctor ordered a chest x-ray and

> completed the exam. They placed my son on antibiotics as he was ill. If we felt he could have waited to see his own doctor, we would have, but as this was late on a Saturday night we felt we had no choice but to seek medical attention for him.

ANALYSIS - B

In reviewing this case, the Commissioner looks not only to the language of the certificate but also to Section 3406k of the Insurance Code, MCL 500.3406k, which states:

> (1) An expense-incurred hospital, medical, or surgical policy or certificate delivered, issued for delivery, or renewed in this state that provides coverage for emergency health services and a health maintenance organization contract shall provide coverage for medically necessary services provided to an insured for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An insurer shall not require a physician to transfer a patient before the physician determines that the patient has reached the point of stabilization. An insurer shall not deny payment for emergency health services up to the point of stabilization provided to an insured under this subsection because of either of the following:
>
> (a) The final diagnosis.
>
> (b) Prior authorization was not given by the insurer before emergency health services were provided.
>
> (2) As used in this section, "stabilization" means the point at which no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient. [Underlining added]

Thus, in a dispute about the medical necessity for emergency treatment, the Commissioner looks not to the final diagnosis but whether there was a "sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health." The Petitioner's own account of the circumstances that led to the decision to seek emergency care is considered as well as any medical records and other contemporaneous reports. An evaluation by an independent review organization may be sought.

This case was presented to an independent review organization (IRO) for analysis as required by Section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6). The IRO reviewer is board certified in emergency medicine and has been in practice for more than 12 years. The IRO report included the following analysis and conclusion:

> The Health Plan indicated that [the Petitioner's] services were not emergent in nature. The Health Plan explained that these services could have been provided at an urgent care center or physician's office. The Health Plan also explained that the emergency room records stated that the member presented with a 4 week history of sickness symptoms. The Health Plan indicated that there was no evidence to suggest that medical treatment had been sought during this 4 week period. The Health Plan also indicated that the records show that the member participated in a school sponsored athletic event in the morning of 4/24/10, but did not present to the emergency room until 9:37 that evening. . . .
>
> * * *
>
> The MAXIMUS physician consultant indicated that the member's symptoms had been occurring for over 4 weeks by the time that he went to the emergency room on 4/24/[10]. The MAXIMUS physician consultant explained that the member had no signs or symptoms of a potentially life threatening condition, such as loss of consciousness, fever, severe headache, chest pain or severe pain. The MAXIMUS physician consultant also explained that although the member was reported to have complained of shortness of breath, his respiratory rate and pulse oximeter reading were both normal. The MAXIMUS physician consultant indicated that any shortness of breath was likely related to an upper respiratory infection. The MAXIMUS physician consultant also indicated that the member could have sought treatment in another setting, such as his primary care physician's office or an urgent care center.

The Commissioner concludes that there was no "sudden onset" of the Petitioner's condition as required by Section 3406k. The emergency room "triage/assessment form" indicated that the Petitioner reported "productive (green and yellow) cough for 4 weeks with sore throat and headache." Furthermore, the Petitioner's chief complaints were "nose bleed, cough, vomiting." As the IRO report stated, there were "no signs or symptoms of a potentially life threatening condition, such as loss of consciousness, fever, severe headache, chest pain or severe pain."

The Commissioner concludes that in this case, there was no reasonable expectation that there would be serious jeopardy to the Petitioner's health in the absence of immediate emergency medical attention.

V. ORDER

The Commissioner upholds CAMADS's final adverse determination of October 25, 2010. Madison National Life Insurance Company, Inc., is not required to cover the Petitioner's emergency room care received on April 24, 2010.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner